STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315207	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT KRESSON VIEW, LLC	2601 EVESHAM ROAD , VOORHEES, New Jersey, 08043

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS Complaint NJ #'s: 171752, 171854, 173717, 173842, 175269, 177162, 178112, 178504, 178566, and 184254 Survey Dates: 7/29/25 to 8/5/25 Census: 212 Sample size: 35 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F0000		09/05/2025
F0584 SS = E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services	F0584	It was determined that the facility failed to maintain a safe, clean, comfortable and homelike environment for our residents. Immediate corrective action for residents affected by deficient practice: Resident rooms and bathrooms [redacted] and [redacted] were cleaned on 08.01.2025 Heating unit in room [redacted] was cleaned of debris on the top of the unit on 08.01.2025 NJ Exec Order 26.4b1 in room [redacted] was replaced on 08.04.2025 Ice machines on all four (4) units were re-cleaned to manufacturer's specification and company policy on 08.01.2025 Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected by the deficient practice.	09/05/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F0584 SS = E	Continued from page 1 necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and pertinent facility documentation, it was determined that the facility failed to: (a) maintain a homelike environment that was clean, safe, and sanitary, and (b) ensure pantry ice machines were maintained in a sanitary condition. This deficient practice was identified for 4 of 4 units ([NJ Exec]-unit, [NJ Exec]-unit, [NJ Exec] unit, and [NJ Exec] -unit) and was evidenced by the following: 1.) On 7/29/2025 at 10:39 AM, in Room [NJ Exec] the surveyor observed the following: Food in clear packaging on the floor next to the resident's bed. Foil lid from a juice container on the floor near the radiator. An empty soda bottle, a fork, a used paper towel, and dried liquid spillage were found under the resident's bed. Brown dried substance on the outer part of the footboard. An accumulation of dust and brown and black substances	F0584	Continued from page 1 Measures put in place to ensure the deficient practice will not occur for those residents affected: Environmental Services staff were re-educated on 08.04.2025, by the Environmental Services Director, on proper daily room and bathroom cleaning procedures, to ensure a safe, clean, comfortable and homelike environment for residents. Beginning on 08.04.2025, staff were re-educated by the Staff Educator, to ensure residents have a safe, clean, and homelike environment. Environmental Services Director/designee will sign off on all Room-A- Day Audits, as a final review. Maintenance Director /designee will include areas for patching and painting rooms on Room-A-Day audits. Maintenance Director/designee will include monthly cleaning of all ice machines, as incorporated in the TELS regulatory compliance program. Monitoring of measures or systemic changes to ensure that the deficiencies will not recur: Environmental Services Director/designee will complete signed Room-A-Day Audits to ensure a safe, clean, comfortable and homelike environment 5x/week x4 weeks and then 3x weekly x2 months. Maintenance Director/designee will complete Room A Day Audits to ensure a safe, clean, comfortable and homelike environment 5x/week x4 weeks - then 3x weekly x2 months. Results of audits will be reported to the Administrator and reviewed at the Monthly Quality Assurance Meeting and Quarterly QAPI Meeting over the duration of the audit process, to ensure compliance as reassessed for further action.	

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F0584 SS = E	Continued from page 2 on the [NJ Exec Order 26.4b1 redacted]. On 7/29/25 at 10:51 AM, in Room [NJ Exec redacted] the surveyor observed the following: Three (3) styrofoam cups and two (2) [NJ Exec Ord redacted] sitting side by side, on the floor, between the resident's bed and nightstand. A white fitted sheet with a [NJ Exec Ord redacted] discoloration. The bedframe contained multiple stains. A brown, rust-like radiator cover vent. Various dried, particle-like stains on the wall near the window and in the bathroom. A buildup of residue on the floor throughout the resident's room and bathroom. [NJ Exec Ord redacted] dried substance on the call bell in the bathroom. A strong [NJ Exec Order 26.4b1 redacted] in the bathroom. On 7/30/25 at 12:26 PM, the surveyor conducted a follow-up visit to Room [NJ Exec redacted] and observed the room was still not cleaned. On 7/30/225 at 12:31 PM, the surveyor conducted a follow-up visit to Room [NJ Exec redacted] and observed [NJ Exec Order 26.4b1 redacted] was still under the resident's bed. On 7/30/25 at 11:29 AM, the surveyor interviewed the [US FOIA (b)(6) redacted] who stated that she cleaned the resident rooms daily. The [US FO redacted] stated that her daily cleaning included but were not limited to; high/low dusting, wiping down the exterior of the radiator, cleaning the walls and bedframe as needed, and sweeping and mopping the floor daily. On 7/31/25 at 10:38 AM, the surveyor interviewed the [US FOIA (b)(6) redacted]), who stated that the housekeepers cleaned each room daily and were responsible for emptying the trash, checking the supplies, high/low dusting, dusting and damp mopping the floors, cleaning the commode and sink, cleaning the exterior of the radiator, the bedframe and walls as needed. He further stated that each room was carbolized (disinfected) monthly.	F0584		

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F0584 SS = E	Continued from page 3 At that time, the surveyor requested a copy of the carbolization (the process of treating or disinfecting, primary used to kill microorganisms and prevent infection) schedule for [NJ Exec Order 25.4]. The surveyor reviewed the schedule, which did not include Room [NJ Exec] On 8/4/2025 at 12:01 PM, the surveyor interviewed the [US FOIA (b)(6)]), who stated that the resident rooms should be kept clean and tidy. She also stated that each room was cleaned daily and disinfected monthly. She further stated that the daily cleaning consisted of, but was not limited to, sweeping, mopping, cleaning the bedframe and footboard, the exterior of the radiator, and walls as needed. The [US FOIA (b)] stated it was everyone's responsibility to pick up items off the resident's floor. A review of the facility's "Cleaning and Disinfecting Residents' Rooms," policy, revised/reviewed January 2019 included, "1. Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. …4. Walls, blinds, and window curtains in resident areas will be cleaned when these surfaces are visibly contaminated or soiled." 2.) On 7/29/25 at 10:34 AM, during the initial tour of the [NJ Exec] unit, the surveyor observed a black substance on the top of the air conditioner unit (AC) located in Room [NJ Exec] On 8/1/25 at 10:40 AM, the surveyor observed the black substance on the top of the AC unit in Room [NJ Exec] On 8/1/25 at 10:45 AM, the surveyor interviewed a housekeeper who stated that the maintenance department cleaned the AC units. On 8/1/25 at 10:57AM, the surveyor interviewed a maintenance employee (ME) who stated that the maintenance department conducted daily rounds called "Room a day" rounds and explained during these rounds, the ME would check a different room every day and record their findings on a check list. The ME further stated that the maintenance department would change the AC unit filters monthly and would paint the outside the AC units if needed. At that time, the ME, in the presence of the surveyor, observed the black substance on top of the AC unit in Room [NJ Exec] The ME stated that he did not observe the black substance when the "Room a Day" was conducted last month but the outside of the AC unit should be clean.	F0584		

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F0584 SS = E	Continued from page 4 On 8/1/25 at 11:37 AM, the surveyor interviewed the US FOIA (b)(6)) who stated that housekeeping was responsible to clean the outside of the units and maintenance would change the filters and paint the AC units as needed. The US FOIA (b provided the surveyor the "Room a Day" checklist that was completed on NJ Exec Order 2 for Room NJ Exec which indicated that the AC unit was operable. On 8/1/25 at 12:54 PM, the surveyor, in the presence of the US FOIA (b interviewed the US FOIA (b who stated that the maintenance department looked at the AC unit which encompassed the entire AC unit, and that the AC unit should be clean. On 8/5/2025 at 9:33 AM, in the presence of the survey team, the US FOIA (b the US FOIA (b)(6) and the US FOIA (b)(6) , the US FOIA (b stated that the housekeeping department was responsible for cleaning the outside of the AC unit when cleaning the room and the Maintenance department was responsible to ensure the AC unit was operable. A review of the facility's "safe and Homelike Environment" policy, dated 9/1/2024, included that housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment. 3.) On 8/1/25 at 8:58 AM, the surveyor toured the nursing units with the US FOIA (b)(6) . The surveyor observed 4 of 4 units ice machine interiors had white and black sediment on the interior of the ice dispensing shoot. On 8/1/25 at 9:25 AM the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM #1) on the NJ Exec unit who stated, if there was a concern for maintenance or housekeeping, all nursing staff was accountable to notify her, place a work order request in the electronic system, or they could call the department directly to report the concern. LPN/UM #1 acknowledged the black and white sediment on the interior of the ice shoot and stated it has the potential to cause an infection. On 8/1/25 at 10:13 AM, the surveyor interviewed the US FOIA (b)(6)) who stated the unit ice	F0584		

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F0584 SS = E	Continued from page 5 machines were cleaned within the time frame suggested by the manufacturer and that the last cleaning was performed on 5/16/25. The [redacted] then acknowledged that the facility had a hard water issue and maybe the cleaning should be done more often. On 8/1/25 at 10:45 AM, the surveyor interviewed the [redacted] who acknowledged that the ice machines were not clean and could cause a health issue for staff and residents. On 8/5/25 at 1:15 PM, in the presence of the survey team, the [redacted] acknowledged the surveyors concerns and had nothing else to provide. A review of the policy titled "Safe and Homelike Environment," dated 9/1/24 revealed…#3) Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment. #9e) Report any furniture in disrepair to maintenance promptly… #9f) Report any unresolved environmental concerns to the administrator. A review of the manufacture guidelines, dated reviewed 1/7/22, Part # [redacted] for the [redacted] Ice machines on the units reads as follows: Preventative maintenance and descaling procedure…descale and sanitize the ice machine every 6 months for efficient operation…If the ice machine requires more frequent descaling and sanitizing consult a qualified service company to test the water quality and recommend appropriate treatment…sanitizing for exterior, remedial and detailed procedures can be performed independently and more frequently then descaling when needed…periodic descaling MUST be performed on adjacent surface areas not contacted by the water distribution system. NJAC 8:39-4.1 (a)11; 31.2(e)	F0584		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may	F0755	The facility failed to accurately account for and document the administration of [redacted] medications. This deficient practice was identifed on 1 of 5 medication carts ([redacted] Floor - Cart #[redacted] Immediate corrective action for residents affected by deficient practice:	09/05/2025

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F0755 SS = D	Continued from page 6 permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of pertinent records, it was determined that the facility failed to accurately account for and document the administration of NJ Exec Order 26.4b1 medications. This deficient practice was identified on 1 of 5 medication carts (NJ Exec floor Cart #NJ E reviewed and was evidenced by the following: On 7/31/25 at 11:45 AM, the surveyor, accompanied by the Licensed Practical Nurse (LPN #1), reviewed the NJ Exec floor nursing unit's medication cart #1. The following was observed when the declining inventory log was reviewed: Resident #123 should have had 29 tablets of NJ Exec Order 26.4b1 but 28 tablets were on hand. LPN #1 at that time, stated she administered the medication during the morning medication pass (8 AM) and failed to sign it out. LPN #1 further stated that NJ Exec Order 26.4b1 medications should be signed out immediately for each dose administered so that the NJ Exec Order 26.4 were accounted for. LPN #1 acknowledged that the NJ Exec Order 2	F0755	Continued from page 6 On 07.31.2025, LPN #1 received 1:1 education from the Staff Educator regarding NJ Exec Order 26.4b substance policy. On 07.31.2025, LPN #1 signed out Resident #123's NJ Exec Order 26.4b medication according to administration time in NJ Exec Order 26.4b Medication Log. Identify those residents who could be affected by the deficient practice: All residents who receive controlled medications have the potential to be affected by the deficient practice. What measures will be put in place to ensure that deficient practice will not occur for those residents affected: On 07.31.2025, an audit was completed by Regional Clinical Director to ensure all narcotic counts were accurate, with no concerns noted. On 07.31.2025, re-education was initiated by Staff Educator, for nurses regarding the policies on 'Medication Administration' and 'Controlled Substance Administration and Accountability' - with a focus on ensuring controlled substances were signed out as per policy. Monitoring of measures or systemic changes to ensure that the deficiencies will not recur: The Director of Nursing/designee will conduct audits of 9 Controlled Substance Declination Inventory Sheets x1 weekly x4 weeks, then 2x monthly x2 months. Results of audits will be reported to the Administrator and reviewed at the Monthly Quality Assurance Meeting and Quarterly QAPI Meetings over the duration of the audit process, to ensure compliance and reassess for further action.	

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F0755 SS = D	Continued from page 7 bingo card (medication packaging method) had 28 doses of NJ Exec Order 26.4b1, and the NJ Exec Order 3 declining sheet revealed there should have been 29 tablets. LPN #1 further stated she did not sign it out when she administered the medication this morning. On 7/31/25 at 11:55 AM, the surveyor interviewed Licensed Practical Nurse/ Unit Manager (LPN/UM #1), who stated that the NJ Exec Order 3 administration record declining sheet should be signed by the nurse immediately when administered. LPN/UM #1 acknowledged and confirmed that there were 28 doses of NJ Exec Order 26.4b1 tablets and that the NJ Exec Order 3 declining sheet revealed 29 tablets remaining. She further acknowledged that LPN #1 did not sign the NJ Exec Order 3 declining sheet when she administered the medication. On 7/31/25 at 12:05 PM, the US FOIA (b)(6)), in the presence of the US FOIA (b)(6) , confirmed that a NJ Exec Order 3 should be signed out by the nurse on the NJ Exec Order 3 declining sheet when the medication was pulled from the bingo card. She further acknowledged that LPN #1 did not sign the declining NJ Exec Order 3 sheet for the NJ Exec Order 26.4b1 8 AM dose when it was administered. A further review of the medication administration audit report indicated the NJ Exec Order 26.4b1 tab 8 AM dose was administered on NJ Exec Order 3 at 8:28 AM and not signed out when compared to their corresponding Medication Administration Records (MAR). On 8/5/25 at 9:34 AM, the US FOIA (b) in the presence of the US FOIA (b)(6) , and the survey team, confirmed that LPN #1 did not sign the NJ Exec Order 3 declining sheet when she administered the medication to the resident. The US FOIA further stated that the nurse should have signed the NJ Exec Order 3 declining sheet when she removed it from the NJ Exec Order 3 bingo card. A review of the facility's "Medication Administration" policy dated 9/1/24, included if a medication is a NJ Exec Order 26.4b1, sign NJ Exec Order 3 book upon removal from inventory. A review of the facility's "Controlled Substance Administration and Accountability" policy with a	F0755		

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F0755 SS = D	Continued from page 8 revised date of 3/17/25, included all controlled substances obtained from a non-automated medication cart or cabinet are recorded on the designated usage form. Written documentation must be clearly legible with all applicable information provided…in all cases, the dose noted on the usage form or entered into the automated dispensing system must match the dose recorded on the medication administration record (MAR), controlled drug record, or other facility specified form and placed in the patient's medical record... NJAC 8:39-29.7(c)	F0755		
F0806 SS = D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to ensure that the resident's [NJ Exec Orde] preferences were accurately implemented for 1 of 10 residents (Resident #14) reviewed for [NJ Exec Order 26] and was evidenced by the following: On 7/31/25 at 12:15 PM, the surveyor observed Resident #14 sitting upright in a [NJ Exec Order 2] chair [NJ Exec Order 26.4b1] [redacted] in the [NJ Exec] Unit dining room being assisted by the US FOIA (b)(6)). The resident's [NJ Exec] indicated [NJ Exec Order 26.4b1] of ground cheesy ham and macaroni casserole, poultry gravy, sautéed spinach with garlic, crustless bread, margarine, vanilla ice cream, chocolate milk, and apple juice. The [NJ Exec Order 26.4b] further indicated, "NJ Exec Order 26.4b1." At that time, the surveyor observed Resident #14's tray	F0806	The facility failed to ensure that Resident #14's [NJ Exec Orde] preferences were accurately implemented. Immediate corrective action for residents affected by deficient practice: Tray ticket for Resident #14 was revised on 07.31.2025 An audit was conducted by the Dining Services Manager on 07.31.2025, of all current resident tray tickets and corresponding meal service for the past 72 hours - with no discrepancies found. Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected by the deficient practice. What measures will be put in place to ensure that deficient practice will not occur for those residents affected: Beginning on 07.31.2025, Dining Services personnel were re-educated by Dining Services Manager/designee on reviewing tray tickets for accuracy of allergies, preferences and substitutes, prior to serving meal. Nursing personnel were re-educated on 08.04.2025, by Staff Educator on reviewing resident tray tickets for accuracy of allergies, preferences, and substitutes, prior to serving.	09/05/2025

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F0806 SS = D	Continued from page 9 included a [NJ Exec Order 26.4b1] of sautéed spinach. On 7/31/25 at 12:30 PM, the surveyor reviewed the medical record for Resident #14. A review of the Admission Record, an admission summary, revealed that the resident had a diagnosis that included but was not limited to [NJ Exec Order 26.4b] [redacted] A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [NJ Exec Order 26.4] included that the resident had a Brief Interview for Mental Status (BIMS) score of [N] out of 15, which indicated the resident's [NJ Exec Order 26] was [NJ Exec Order 26.4b1]. A review of the individual comprehensive care plan (ICCP) included a focus area, dated [NJ Exec Order 26.4b], that the resident was at risk for [NJ Exec Order 26.4b1] interventions included: [NJ Exec Order 26.4b1] and NJ Exec Order 26.4b1, dislikes [NJ Exec Order 26.4b1]. A review of the Order Summary Report (OSR) included a NJ Exec Order 26.4b1 [redacted] On 7/31/25 at 12:15 PM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1, who confirmed the resident's lunch contained sauteed spinach. She stated that meals were served according to the resident's likes and dislikes. LPN/UM #1 stated that she would provide the resident with a [NJ Exec Order 26.4] for the [NJ Exec Order 26.4b1]. On 8/1/25 at 9:03 AM, the surveyor interviewed the [US FOIA] [redacted] who stated that the meals should be accurate. She further stated that the [NJ Exec Orde] team collaborated with the nursing team, and the trays are double-checked before being given to the resident. She also said that "NJ Exec Order 26.4b1" should not have been written on the [NJ Exec Order 26.4b] because the resident "[NJ Exec Order 26.4b1]." On 8/1/25 at 10:02 AM, the surveyor interviewed the US FOIA (b)(6) [redacted]), who stated that the food trays should be accurate as shown on the [NJ Exec Order 26.4b]. She further stated that food preferences could change, and they should be communicated to [NJ Exec Orde] services and honored. The [US FO] also stated that if there was a discrepancy on the [NJ Exec Order 26.4b], it should be clarified immediately.	F0806	Continued from page 9 Monitoring of measures or systemic changes to ensure that the deficiencies will not recur: Dining Services Manager/designee will complete tray assessments, inclusive of tray accuracy for allergies, preferences, and substitutes. Audits will be completed 3x per week x4 weeks, then 2x weekly x2 months. Results of audits will be reported to the Administrator and reviewed at the Monthly Quality Assurance Meeting and Quarterly QAPI Meetings over the duration of the audit process, to ensure compliance and reassessed for further action.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315207	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT KRESSON VIEW, LLC	2601 EVESHAM ROAD , VOORHEES, New Jersey, 08043

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F0806 SS = D	Continued from page 10 On 8/4/2025 at 11:50 AM, the surveyor interviewed the [redacted], who stated that the [redacted] visited the resident upon admission and discussed the resident's likes and dislikes. She further noted that the person delivering the tray was supposed to check it for [redacted] before giving it to the resident. The [redacted] stated that if there was any discrepancy, the [redacted] should be notified, and the matter should be followed up. On 8/4/25 at 12:01 PM, the surveyor interviewed the [redacted], who acknowledged that the [redacted] and trays should be accurate. A review of the facility's "Dining and Food Preferences" policy, revised September 2017, included: "Upon meal service, any resident/patient with expressed or observed refusal of food and/or beverage will be offered an alternate selection of comparable nutrition value. NJAC 8:39-17.4(e)	F0806		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;	F0880	The facility failed to follow appropriate infection control practices, specifically the use of Personal Protective Equipment (PPE), during [redacted] tours, to residents who require [redacted] to prevent the potential spread of infection in accordance with the Center for Disease Control and Prevention (CDC) guidelines and standards of clinical practice. This deficient practice was identified for 2 of 2 residents (Resident #180 and Resident #188). Immediate corrective action for residents affected by the deficient practice: On 08.04.2025, RN/UM#1 was re-educated by the Director of Nursing on [redacted]. On 08.04.2025, RN/UM#2 was re-educated by the Director of Nursing on [redacted]. On 08.04.2025, CNA #2 was re-educated by the Director of Nursing on [redacted]. Identify those individuals who could be affected by the deficient practice:	09/05/2025

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F0880 SS = D	Continued from page 11 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by:	F0880	Continued from page 11 All residents who have orders for Enhanced Barrier Precautions, have the potential to be affected by the deficient practice. What measures will be put in place to ensure that deficient practice will not occur for those residents affected: On 08.04.2025, re-education was initiated by Infection Control Preventionist to nursing staff, on Enhanced Barrier Precautions, with an emphasis on ensuring gowns are worn when required. Monitoring of measures or systemic changes to ensure that the deficiencies will not recur: The Director of Nursing/designee will conduct audits of 10 residents with Enhanced Barrier Precautions to ensure staff are wearing appropriate PPE. Audits will be completed x4 weeks then monthly x2 months. Results of audits will be reported to the Administrator and reviewed at the Monthly Quality Assurance Meeting and QAPI quarterly meeting, over the duration of the audit process, to ensure compliance and reassessed for further action.	

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F0880 SS = D	Continued from page 12 Based on observation, interview and review of pertinent facility documentation, it was determined that the facility failed to follow appropriate infection control practices, specifically the use of Personal Protective Equipment (PPE) during NJ Exec Order 26.4b1 tours to residents who required NJ Exec Order 26.4b1 [redacted], to prevent the potential spread of infection in accordance with the Center for Disease Control and Prevention (CDC) guidelines and standards of clinical practice. This deficient practice was identified for 2 of 2 residents (Resident #180 and Resident #188) and was evidenced by the following: According to the CDC Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes, dated 6/28/24, EBP are recommended for residents with indwelling devices or wounds … because devices and wounds are risk factors that place these residents at higher risk for carrying or acquiring a MDRO (multidrug-resistant organisms) and many residents colonized with a MDRO are asymptomatic or not presently known to be colonized. EBP expand the use of gown and gloves beyond anticipated blood and body fluid exposures. They focus on use of gown and gloves during high-contact resident care activities that have been demonstrated to result in transfer of MDROs to hands and clothing of healthcare personnel, even if blood and body fluid exposure is not anticipated. EBP are recommended for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices) ...https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html 1. On 7/30/25 at 8:54 AM, during an NJ Exec Order 26.4b1 tour with Registered Nurse/ Unit Manager #1 (RN/ UM #1), the surveyor observed an NJ Exec O sign on Resident #180's door and an NJ Exec Order 26.4b on the resident's name posted outside the room. RN/ UM#1 sanitized their hands with an alcohol-based hand sanitizer (ABHS) and wore gloves but did not put on a gown. RN/ UM #1 pulled away the resident's bed linen and exposed the resident's NJ Exec Or [redacted] The surveyor observed the NJ Exec Order 26.4b1 with the bedsheet under the resident's NJ Exec Order 26.4b1. Resident #180 stated that they NJ Exec Order 26.4b1. The surveyor asked RN/ UM#1 to NJ Exec Order the back of the NJ Exec O RN/ UM #1 NJ Exec Orde the resident to the NJ Exec and NJ Exec Order 26.4b1 the NJ Exec Order 26.4b1 to NJ Exec Order the back of the resident. The NJ Exec Order 26.4b1 was observed to be NJ Exe at the back. RN/ UM #1 NJ Exec Order 26 the NJ Exec O and	F0880		

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F0880 SS = D	Continued from page 13 stated to the surveyor that the resident would get [redacted]. On 7/30/25 at 12:06 PM, the surveyor reviewed the electronic medical record (EMR) for Resident #180. A review of the Admission Record revealed that the resident was admitted to the facility with diagnoses which included but not limited to [redacted]. A review of the most current comprehensive Minimum Data Set (MDS), an assessment tool dated [redacted], revealed that the resident had [redacted]. A review of the Clinical Physician Orders completed and active as of [redacted] revealed the following order: Resident requires [redacted] for a diagnosis of [redacted] w/ [redacted] ordered on [redacted]. A review of the resident's comprehensive care plan as of [redacted] indicated a focus for the resident requiring [redacted] related to [redacted] with [redacted] in place. Interventions initiated on [redacted] included the following: Clear signage must be posted on the door or wall outside of the resident room indicating the type of [redacted] and required PPE. For [redacted], signage should also clearly indicate the [redacted] resident care activities that require the use of gown and gloves. 2. On 7/30/2025 at 9:22 AM, during an [redacted] tour with Registered Nurse/ Unit Manager #2 (RN/ UM) #2, the surveyor observed an [redacted] sign on Resident #188's door and an [redacted] on the resident's name posted outside the room. RN/ UM #2 sanitized their hands with an ABHS and wore gloves. RN/ UM #2 asked the assistance of Certified Nursing Assistant #2 (CNA #2) for [redacted] the resident. CNA #2 sanitized their hands with ABHS and put gloves on. Both RN/ UM #2 and CNA #2 did not put on a gown. RN/ UM #2 [redacted] the resident's [redacted]. The [redacted] was observed to be [redacted] The surveyor asked RN/ UM #2 to [redacted]. RN/ UM #2 with the assistance of CNA #2 [redacted] the resident to the [redacted] and [redacted] the [redacted] from the back side which appeared [redacted] There was also a small amount of [redacted]. RN/ UM #2 stated that the resident [redacted]. On 7/30/25 at 12:07 PM, the surveyor reviewed the EMR	F0880		

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F0880 SS = D	Continued from page 14 for Resident #188. A review of the Admission Record revealed that the resident was admitted to the facility with diagnoses which included but not limited to [redacted] A review of the most current comprehensive Minimum Data Set (MDS), an assessment tool dated [redacted] revealed that the resident had [redacted]. A review of the Clinical Physician Orders completed and active as of [redacted] revealed the following order: Resident requires [redacted] for a [redacted]), history of [redacted] to [redacted] every shift for [redacted] started on [redacted] A review of the resident's comprehensive care plan as of [redacted] indicated a focus for the resident requiring [redacted] for [redacted]. Interventions initiated on [redacted], included the following: Clear signage must be posted on the door or wall outside the resident's room indicating the type of [redacted] and required PPE. For [redacted] signage should also clearly indicate the [redacted] resident care activities that require the use of gown and gloves. On 8/1/25 at 11:03 AM, during an interview with the survey team, the [redacted]) stated that [redacted] activities requiring [redacted] include [redacted] care, [redacted] and [redacted] care. The [redacted] also stated that the PPEs required for [redacted] included gloves and gowns. On 8/1/25 at 11:39 AM, during an interview with the surveyor, the [redacted] stated that [redacted] activities requiring [redacted] include direct care and extended period activities with residents on [redacted] including opening and closing of [redacted] A review of the facility-provided policy date implemented on 9/1/2024 titled "Enhanced Barrier Precaution" under Policy Explanation 1.b.) An order for enhanced barrier precautions will be obtained for residents with any of the following: i.) Wounds … ii.)	F0880		

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F0880 SS = D	Continued from page 15 Infection or colonization with CDC-targeted MDRO when contact precautions do not otherwise apply. N.J.A.C. 8:39 – 19.4 (a)	F0880		

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S0000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations	S0000		09/05/2025
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Complaint NJ #'s: 173717, 173842, 177162, and 178504 Based on interviews, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was identified for 55 out of 56 day shifts and 1 of 14 evening shifts reviewed and was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021:	S0560	The facility failed to supply sufficient number of Nursing staff in accordance with CFR (s): 8:39-5.1 (a). Immediate corrective action for those residents affected by deficient practice: The facility continues to actively fill all open Certified Nursing Assistant (CNA) shifts to comply with New Jersey State mandated ratios. Minimum staffing requirements were reviewed with the Human Resources Director and Staffing Coordinator, who were both able to reiterate minimum staffing requirement for nursing homes. Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected by the deficient practice. Measures put in place to ensure the deficient practice will not occur for those residents affected: The facility will continue to focus on recruitment and retention strategies as follows; Identify vacant positions daily and attempt to fill positions with	09/05/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S0560	Continued from page 1 One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the 2 weeks of Complaint staffing from 05/12/2024 to 05/25/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shift as follows: -05/12/24 had 16 CNAs for 235 residents on the day shift, required at least 29 CNAs. -05/13/24 had 17 CNAs for 235 residents on the day shift, required at least 29 CNAs. -05/14/24 had 27 CNAs for 235 residents on the day shift, required at least 29 CNAs. -05/15/24 had 27 CNAs for 235 residents on the day shift, required at least 29 CNAs. -05/16/24 had 26 CNAs for 237 residents on the day shift, required at least 30 CNAs. -05/17/24 had 24 CNAs for 232 residents on the day shift, required at least 29 CNAs. -05/18/25 had 24 CNAs for 230 residents on the day shift, required at least 29 CNAs. -05/19/24 had 22 CNAs for 229 residents on the day shift, required at least 29 CNAs. -05/20/24 had 15 CNAs for 229 residents on the day shift, required at least 29 CNAs. -05/21/24 had 26 CNAs for 229 residents on the day shift, required at least 29 CNAs.	S0560	Continued from page 1 current CNA staff or agency personnel. The Administrator and Director of Nursing will work diligently with Corporate Recruiters to advertise, recruit and hire sufficient CNA staff. Administrator to continue to work with Human Resources Director and Staffing Coordinator, to offer shift bonuses and flexible schedules. Administrator and Human Resources Director will continue to focus on recruitment and employer sponsorship of qualified candidates for enrollment in a Certified Nursing Assistant Training and Competency Program. Administrator and Human Resources Director will continue to develop and employee retention program, designed to engage employees, promote a positive work environment and enhance job satisfaction. Administrator will educate the Staffing Coordinator on the process to project staffing needs based on facility census fluctuations, to meet mandated ratios. Monitoring of measures or systemic changes to ensure that the deficiencies will not recur: Administrator/designee to audit effectiveness of hiring strategies to include open CNA and Licensed Nurse positions vs. new hires, reporting on successful strategies-to-hire, based on percentages and turnover rates. The duration of all audits will consist of completion 1xweekly x4 weeks, then continue 1x weekly x2 months. All findings will be brought to the Administrator and reviewed in Quality Assurance Meeting monthly for recommendations. Results of audits will be reported to the Administrator and reviewed at the Monthly Quality Assurance Performance Improvement Meeting and Quarterly QAPI meetings.	

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S0560	Continued from page 2 -05/22/24 had 25 CNAs for 229 residents on the day shift, required at least 29 CNAs. -05/23/24 had 27 CNAs for 229 residents on the day shift, required at least 29 CNAs. -05/24/24 had 22 CNAs for 228 residents on the day shift, required at least 28 CNAs. -05/25/24 had 20 CNAs for 227 residents on the day shift, required at least 28 CNAs. 2. For the 2 weeks of Complaint staffing from 09/08/2024 to 09/21/2024, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows: -09/08/24 had 21 CNAs for 217 residents on the day shift, required at least 27 CNAs. -09/09/24 had 18 CNAs for 217 residents on the day shift, required at least 27 CNAs. -09/10/24 had 22 CNAs for 217 residents on the day shift, required at least 27 CNAs. -09/11/24 had 23 CNAs for 217 residents on the day shift, required at least 27 CNAs. -09/12/24 had 24 CNAs for 220 residents on the day shift, required at least 27 CNAs. -09/13/24 had 24 CNAs for 220 residents on the day shift, required at least 27 CNAs. -09/14/24 had 18 CNAs for 220 residents on the day shift, required at least 27 CNAs. -09/15/24 had 14 CNAs for 220 residents on the day shift, required at least 27 CNAs. -09/16/24 had 16 CNAs for 220 residents on the day shift, required at least 27 CNAs. -09/17/24 had 25 CNAs for 220 residents on the day shift, required at least 27 CNAs. -09/18/24 had 24 CNAs for 220 residents on the day shift, required at least 27 CNAs.	S0560		

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S0560	Continued from page 3 -09/19/24 had 25 CNAs for 220 residents on the day shift, required at least 27 CNAs. -09/20/24 had 23 CNAs for 217 residents on the day shift, required at least 27 CNAs. 3. For the 2 weeks of Complaint staffing from 10/06/2024 to 10/19/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -10/06/24 had 13 CNAs for 219 residents on the day shift, required at least 27 CNAs. -10/07/24 had 16 CNAs for 219 residents on the day shift, required at least 27 CNAs. -10/08/24 had 16 CNAs for 219 residents on the day shift, required at least 27 CNAs. -10/09/24 had 25 CNAs for 219 residents on the day shift, required at least 27 CNAs. -10/10/24 had 26 CNAs for 218 residents on the day shift, required at least 27 CNAs. -10/11/24 had 24 CNAs for 217 residents on the day shift, required at least 27 CNAs. -10/12/24 had 16 CNAs for 217 residents on the day shift, required at least 27 CNAs. -10/13/24 had 15 CNAs for 216 residents on the day shift, required at least 27 CNAs. -10/14/24 had 16 CNAs for 215 residents on the day shift, required at least 27 CNAs. -10/15/24 had 25 CNAs for 213 residents on the day shift, required at least 27 CNAs. -10/16/24 had 23 CNAs for 213 residents on the day shift, required at least 27 CNAs. -10/17/24 had 23 CNAs for 213 residents on the day shift, required at least 27 CNAs. -10/18/24 had 24 CNAs for 213 residents on the day shift, required at least 27 CNAs. -10/19/24 had 25 CNAs for 213 residents on the day	S0560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060413	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT KRESSON VIEW, LLC	2601 EVESHAM ROAD , VOORHEES, New Jersey, 08043

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0560	Continued from page 4 shift, required at least 27 CNAs. 4. For the 2 weeks of staffing prior to survey from 07/13/2025 to 07/26/2025, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts and deficient in total staff for residents on 1 of 14 evening shifts as follows: -07/13/25 had 16 CNAs for 202 residents on the day shift, required at least 25 CNAs. -07/14/25 had 16 CNAs for 202 residents on the day shift, required at least 25 CNAs. -07/15/25 had 17 CNAs for 201 residents on the day shift, required at least 25 CNAs. -07/16/25 had 21 CNAs for 201 residents on the day shift, required at least 25 CNAs. -07/17/25 had 16 CNAs for 200 residents on the day shift, required at least 25 CNAs. -07/18/25 had 16 CNAs for 200 residents on the day shift, required at least 25 CNAs. -07/19/25 had 18 CNAs for 200 residents on the day shift, required at least 25 CNAs. -07/20/25 had 18 CNAs for 200 residents on the day shift, required at least 25 CNAs. -07/21/25 had 18 CNAs for 200 residents on the day shift, required at least 25 CNAs. -07/22/25 had 20 CNAs for 201 residents on the day shift, required at least 25 CNAs. -07/23/25 had 20 CNAs for 201 residents on the day shift, required at least 25 CNAs. -07/24/25 had 18 CNAs for 201 residents on the day shift, required at least 25 CNAs. -07/25/25 had 21 CNAs for 206 residents on the day shift, required at least 26 CNAs. -07/26/25 had 18 CNAs for 206 residents on the day shift, required at least 26 CNAs. -07/26/25 had 20 total staff for 206 residents on the	S0560		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0560	Continued from page 5 evening shift, required at least 21 total staff. On 7/29/2025 at 10:20 AM, during the entrance conference the Licensed Nursing Home Administrator (LNHA) stated in the presence of the Director of Nursing (DON) and the surveyor that the facility utilized agency staff and that she felt staffing was fine. On 8/1/2025 at 9:38 AM, the surveyor interviewed the DON who stated that the facility met the staffing requirements and built their schedules based on what was needed to care for residents. She stated that the staffing levels were determined by using the resident acuity and the Department of Health guidelines. She further stated that the levels were reassessed daily and every shift, especially on the first floor. The DON stated when the resident census increased, the facility brought in additional staff to keep up with the demand. She explained in the event of call-outs or unexpected shortages, the facility used agency staff, offered bonuses to current staff to pick up shifts, and had management step in when necessary. The facility also partnered with a certified nursing assistant (CNA) program to help current staff become certified, which supported growing their own team of CNAs. A review of the facility's "Nursing Services and Sufficient Staff" policy dated revised 3/6/25, included, 1. The facility will supply services by sufficient numbers of each of the following personnel types on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans.	S0560		
S1680	Mandatory Nurse Staffing CFR(s): 8:39-25.2(b)(1)&(2) (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a)) on the basis of: 1. Total number of residents multiplied by 2.5 hours/day; plus	S1680	The facility failed to supply sufficient number of Nursing staff in accordance with CFR (s): 8:39-25.2 (b) (1) & (2). Immediate corrective action for those residents affected by deficient practice: The facility continues to actively fill all open Licensed Nurses and Certified Nursing Assistant (CNA) shifts to comply with New Jersey State mandated ratios. Minimum staffing requirements were reviewed with the Human Resources Director and Staffing Coordinator, who were both able to reiterate minimum staffing requirement for nursing homes.	09/05/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060413	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/05/2025

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S1680	Continued from page 6 2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day: Wound care 0.75 hour/day Nasogastric tube feedings and/or gastrostomy 1.00 hour/day Oxygen therapy 0.75 hour/day Tracheostomy 1.25 hours/day Intravenous therapy 1.50 hours/day Use of respirator 1.25 hours/day Head trauma stimulation/advanced neuromuscular/orthopedic care 1.50 hours/day This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on review of the Nursing Staffing Reports for the two weeks prior to survey from 7/13/2025 to 7/26/2025, the facility was deficient in total staffing on 1 of 14 days. The required staffing hours and actual staffing hours are as follows: For the week of 07/20/25 Required staffing hours: 555.75 -07/26/25 had 536 actual staffing hours, for a difference of -19.75 hours. On 7/29/2025 at 10:20 AM, during the entrance conference the Licensed Nursing Home Administrator (LNHA) stated in the presence of the Director of Nursing (DON) and the surveyor that the facility utilized agency staff and that she felt staffing was fine.	S1680	Continued from page 6 Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected by the deficient practice. Measures put in place to ensure the deficient practice will not occur for those residents affected: The facility will continue to focus on recruitment and retention strategies as follows; Identify vacant positions daily and attempt to fill positions with current CNA/Licensed Nurses staff or agency personnel. The Administrator and Director of Nursing will work diligently with Corporate Recruiters to advertise, recruit and hire sufficient Licensed Nurses/CNA staff. Administrator to continue to work with Human Resources Director and Staffing Coordinator, to offer shift bonuses and flexible schedules. Administrator and Human Resources Director will continue to focus on recruitment and employer sponsorship of qualified candidates for enrollment in a Certified Nursing Assistant Training and Competency Program. Administrator and Human Resources Director will continue to develop and employee retention program, designed to engage employees, promote a positive work environment and enhance job satisfaction. Administrator will educate the Staffing Coordinator on the process to project staffing needs based on facility census fluctuations, to meet mandated ratios. Monitoring of measures or systemic changes to ensure that the deficiencies will not recur: Administrator/designee to audit effectiveness of hiring strategies to include open CNA and Licensed Nurse positions vs. new hires, reporting on successful strategies-to-hire, based on percentages and turnover rates. The duration of all audits will consist of completion 1xweekly x4 weeks, then continue 1x weekly x2 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060413	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/05/2025

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S1680	Continued from page 7 On 8/1/2025 at 9:38 AM, the surveyor interviewed the DON who stated that the facility met the staffing requirements and built their schedules based on what was needed to care for residents. The DON stated when the resident census increased, the facility brought in additional staff to keep up with the demand. A review of the facility's "Nursing Services and Sufficient Staff" policy dated revised 3/6/25, included, 1. The facility will supply services by sufficient numbers of each of the following personnel types on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans.	S1680	Continued from page 7 All findings will be brought to the Administrator and reviewed in Quality Assurance Meeting monthly for recommendations. Results of audits will be reported to the Administrator and reviewed at the Monthly Quality Assurance Performance Improvement Meeting and Quarterly QAPI meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315207	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/09/2025

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F0000	INITIAL COMMENTS An offsite/ desk review of the facilities POC was conducted on 9/9/25 in relation to the 8/5/25 recertification survey. The facility was found to be in compliance 42 CFR Part 483, requirements for LTC facilities.	F0000		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060413	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/09/2025

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S0000	Initial Comments An offsite/ desk review of the facilities POC was conducted on 9/9/25 in relation to the 8/5/25 recertification survey. The facility was found to be in compliance 42 CFR Part 483, requirements for LTC facilities.	S0000		

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025

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K0000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations from 07/29/2025 to 07/31/2025. Complete Care at Kresson View was found to be in NON-COMPLIANCE with requirements for participation in Medicare/Medicaid at 42 CFR 483.90 (A) Life Safety from fire and the 2012 edition of the National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Complete Care at Kresson View is a four-story building that was built in 1963 and 1986. The 1963 addition has a partial basement that is unoccupied and is separated from the nursing home with a two-hour separation. The 1986 addition is of Type II (222) construction and is fully sprinklered with battery-operated smoke detection in resident rooms and has hard-wired smoke detection in corridors and spaces open to the corridor. The original 1963 portion of the building is Type V construction with rafters and wood frame, masonry exterior. The diesel generator carries approximately 40% of the building load according to the Maintenance Director. The fire system is Township pressure. The 1963 portion is serviced by a dry sprinkler system. The 1986 addition is serviced by a wet system with the exception of the exterior sprinklers under the drop -off area at the front door and rear patio area.	K0000		09/05/2025
K0281 SS = F	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This STANDARD is NOT MET as evidenced by:	K0281	The facility failed to ensure that illumination of egress was provided at exits, exit doors and exit discharges, in accordance with NFPA 101:2012 Edition, Sections 7.8.1.4 and 19.2.8 Immediate corrective action for residents affected by this deficient practice: Director of Maintenance ordered 2 dual LED light fixtures and installed on 08.05.2025 Identify those individuals who could be affected by	09/05/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K0281 SS = F	Continued from page 1 Based on observations and interviews on 7/30/2025 in the presence of the [redacted], it was determined that the facility failed to ensure that illumination of egress was provided at exits, exit doors and exit discharges in accordance with NFPA 101:2012 Edition, Sections 7.8.1.4 and 19.2.8. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 7/30/2025 at approximately 11:30 AM and 7/31/25 at approximately 10:00 AM revealed the following exit doors were not equipped with a light fixture.The exit from the Boiler Room located in the front of the building.The exit closest to the Supervisor office located at the front of the building. In interviews at these times, the [redacted] confirmed the observations. The facility's [redacted] was informed of the deficient practice during the Life Safety Code exit conference on 7/31/2025 at 11:47 AM. NJAC 8:39-31.2(e)	K0281	Continued from page 1 this deficient practice: All residents have the potential to be affected by this deficient practice. Measures put in place to ensure the deficient practice will not occur for those residents affected: Administrator re-educated Maintenance Department regarding illumination of egress to be provided at exits, exit doors and exit discharges, in accordance with NFPA 101:2012 Edition, Sections 7.7, 1.4 and 19.2.8 (08.04.2025) Director of Maintenance/designee will include weekly on facility's electronic Regulator Monitoring platform, to ensure functioning illumination for means of egress in those depicted areas. Monitoring of measures or systemic changes to ensure that the deficiencies will not recur: The Maintenance Director/designee will conduct audits of the 2 dual LED light fixtures installed for functioning illumination of means of egress. Audits will be completed weekly x4 weeks, then 1x monthly x 2 months to ensure compliance. Results of audits will be reported to the Administrator and reviewed at the Monthly Quality Assurance Meeting and Quarterly QAPI Meetings, over the duration of the audit process to ensure compliance and reassessed for further action.	
K0347 SS = F	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This STANDARD is NOT MET as evidenced by:	K0347	Ftag 0353 - Weekly documentation was provided (as attachment) - this week's audit is scheduled for tomorrow 08/29/2025.	09/05/2025

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K0347 SS = F	Continued from page 2 Based on observation, record review and interview on 7/29/2025 in the presence of the [redacted], it was determined that the facility failed to properly document testing and maintenance of battery-operated smoke detectors in resident rooms, in an existing structure in accordance with NFPA 101 Life Safety Code 2012 edition 19.3.6.1 and 19.3.4.5.2. This deficient practice was identified for all battery-operated smoke detectors, had the potential to affect all residents and was evidenced by the following: A record review on 7/29/2025 showed the Monthly Smoke Detector Test Log did not include documentation for date of install, date of replacement, make, model, or type of battery powering smoke detector. In an interview with [redacted] on 7/29/2025 at approximately 10:30 AM, the [redacted] confirmed that the facility provided inspection sheet did not include the required information. The facility [redacted] was informed of the deficient practice during the Life Safety Code exit conference on 7/31/2025 at 11:47 AM. NJAC 8:39-31.2(e)	K0347		
K0353 SS = F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____	K0353	Ftag 0353 - Picture will be provided upon completion of work - on 09/05/2025	09/05/2025

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K0353 SS = F	Continued from page 3 Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation and interviews on 7/30/2025 in the presence of the US FOIA (b)(6) [redacted]), it was determined that the facility failed to maintain the sprinkler system and ensure the ceiling level was smoke resistant in accordance with NFPA 25: 2011 Edition. This deficient practice could affect all residents and was evidenced by the following: An observation at 12:35 PM revealed that the front overhang, (portico), had multiple penetrations throughout the outer edge. These penetrations lead directly to a wooden structure above and encompasses three stories of the building. One opening was approximately 3-inch by 2-foot with the largest section being approximately 4-inch by 4-foot. In an interview at the time the US FOIA (b)(6) confirmed resident areas were located directly above and the [redacted] stated that "it is also right under the Dining Room". US FOIA (b)(6) agreed that it was a constant problem "as the room Air conditioning units condensation constantly dripped down to the ceiling". Both the US FOIA (b)(6) confirmed the observation. The facility's US FOIA (b)(6) was notified of the deficient practice during the Life Safety Code exit conference on 7/31/2025 at 11:47 AM. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K0353		
K0372 SS = F Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction	K0372	Revised: Correct Caulking Sealant used has been clarified as [redacted] Fire Barrier Sealant	09/05/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0372 SS = F Bldg. 01	Continued from page 4 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: Based on observation and interview on 7/31/2025, in the presence of the US FOIA (b)(6)), it was determined that the facility failed to ensure that penetrations through smoke/fire barriers were protected by a system or materials capable of restricting the transfer of fire/smoke in accordance with NFPA 101:2012 Edition, Section 8.5.6, 8.3.5, NFPA 105 and NFPA 80:2010 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 9:06 AM of the fire/smoke barrier wall above the ceiling tile, located at the fire doors separating the original building from the addition, revealed unsecured penetrations. One penetration approximately 4-inch by 4 inches, with a condenser line set running through and one approximately 6-inch by 6-inch penetration with an approximately 1-inch and half copper pipe running through. In an interview at 9:10 AM, the US FO confirmed the observations. The facility US FOIA (b)(6) was notified of the deficient practice during the Life Safety Code exit conference at 11:47 AM. NJAC 8:39-31.2(e)	K0372	Continued from page 4 Pictures displayed in attachments.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315207	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT KRESSON VIEW, LLC	**2601 EVESHAM ROAD , VOORHEES, New Jersey, 08043**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An Emergency Preparedness Survey was conducted by the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 7/29/2025, 7/30/2025 and 7/31/2025. The facility was found to be in compliance with Medicare/Medicaid at 42 CFR, Subpart 483.73, Emergency Preparedness.	E0000		09/05/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 11/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT KRESSON VIEW, LLC	2601 EVESHAM ROAD , VOORHEES, New Jersey, 08043

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000 Bldg. 01	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 11/10/2025 in relation to the 8/5/2025 Life Safety Code survey. The facility was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy.	K0000		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE